VERMONT2009

The Implementation of Act 114 at the Vermont State Hospital

Report from the Commissioner of Mental Health
to the General Assembly
January 15, 2009

VERMONT

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Executive Summary

Vermont's Act 114 addresses three areas of mental-health law:

- The administration of non-emergency involuntary psychiatric medication in inpatient settings for people on orders of hospitalization
- The administration of non-emergency involuntary psychiatric medication in inpatient settings for people on orders of non-hospitalization (community commitments), and
- Continuation of ninety-day orders of non-hospitalization

The statute allows for orders of non-hospitalization, whether ninety-day or one-year orders, to be renewed following a hearing. Prior to implementation of Act 114, ninety-day orders could not be renewed.

Among other things, the Act replaced administrative hearings on applications for non-emergency involuntary medication with judicial hearings in family court. The statute permits the administration of involuntary psychiatric medication in non-emergency situations to patients who have been committed to the care and custody of the Commissioner of Mental Health in Commissioner-designated hospitals in the community as well as at the Vermont State Hospital (VSH). At present, however, non-emergency involuntary psychiatric mediations are given only at VSH.

Section 5 of Act 114 requires an annual report from the Commissioner of Mental Health on the implementation of the provisions of the act to the House Judiciary and Human Services Committees and to the Senate Committees on Judiciary, and Health and Welfare. The statute specifies four sections for the report, to set forth:

I. Any problems that the department, the courts, and the attorneys for the state and patient have encountered in implementing the provisions of the statute
II. Number of petitions for involuntary medication filed by the state pursuant to 18 V.S.A. §7624 and the outcome in each case
III. Copies of any trial court or supreme court decisions, orders, or administrative rules interpreting Section 4 of this act, and
IV. Any recommended changes in the law.

In addition, the statute requires the Commissioner of Mental Health to solicit comments from organizations representing persons with mental illness and organizations representing families with members with mental illness, direct-care providers, persons who have been subject to proceedings under 18 V.S.A. §7624, treating physicians, attorneys for the patients, courts, and any other member of the public affected by or involved in these proceedings.

INTRODUCTION

The annual report on the implementation of Act 114 is submitted for your review on behalf of Vermont's Department of Mental Health (DMH). You will find that under Act 114 the state filed 24 petitions for involuntary medication between January 1 and December 31, 2008. Seven of those petitions were withdrawn before hearing as the patients identified began taking medication on a voluntary basis. The court denied the state's request in one case, and one petition was pending as of the end of 2008. The court granted the state's request in the remaining 15 petitions and issued orders for involuntary medication of those individuals.

The 15 patients who were involuntarily medicated are 6% of the 249 individuals who were served at the Vermont State Hospital (VSH) between January 1 and December 31, 2008. Of those 15 persons, four were well enough to be discharged from VSH before the end of the year.

Only two of the 15 people who were involuntarily medicated under the Act 114 process in 2008 answered the Commissioner's questionnaire. An additional two individuals who were actually medicated in 2007 answered questionnaires that were not received at DMH until after January 1 of 2008, thus too late to be included in the 2007 report that was filed on January 15, 2008. Those two questionnaires are included here along with the one questionnaire received from a patient medicated in 2008. Ten of the patients involuntarily medicated this year did not begin receiving their medication until September or later, and so it is possible that they have not had enough time to answer the Commissioner's questions for inclusion in this report.

The use of Act 114 is not a panacea for persons who are seriously ill at VSH, and DMH recognizes the possibility that persons may stop the use of medication following discharge. A review of records from 2003 through 2008 indicates that of ninety-four unduplicated individuals receiving an involuntary medication order under Act 114, eighteen were on orders of nonhospitalization (ONH) in the community on December 31, 2008. Eleven more were still in the Vermont State Hospital after receiving orders for medication under Act 114 in 2008.

Eleven, or 73%, of the 15 persons medicated under Act 114 in 2008 had not been discharged from VSH by the end of December. Eight of the petitions for involuntary medication were granted in the last three months of 2008. Recovery can be slow in developing or the medication is only a part of the treatment that will move them toward discharge. The situation is far from ideal, as the use of coercion to gain treatment progress is perhaps the least preferred avenue on which to move toward recovery. Nonetheless, it is also clear that medication, whether voluntary or involuntary, is often a key component of recovery and symptoms can be alleviated through its use.

Readers of this document will find a rich variety of perspectives about the Act 114 process and the use of involuntary psychiatric medication as part of the course of treatment for those adults with the most refractory mental illnesses. All of these views

are included to illustrate the range of opinions and the complexities of the issues that must be addressed. The hope is that this information will add to discussions of the use of medication as an intervention and the ongoing struggle that care providers have in trying to improve patient outcomes.
It is well to note here that 94 individuals have been involuntarily medicated at the Vermont State Hospital since the implementation of Act 114 in 2003. Seventy-eight, or 83 percent, of those individuals have been through the Act 114 process only once, while sixteen of them, or 17 percent, have been through the process two or more times.

Reviewing information from other states in regard to the administration of involuntary psychiatric medications in non-emergency situations, DMH continues to find that Vermont is among a few states where this involuntary medication process is beyond a 20-30-day period. DMH will continue to pursue changes in the process so that people in need of treatment can get it without decreasing the legal protections that they have in place. We have been engaged in discussions within the Executive Branch and with legislators, the judiciary, and advocates on the best means of moving toward that end; those discussions are ongoing. Ideally, the time from inpatient admission to the beginning of medication for any individual should be less than thirty days.

PROBLEMS WITH IMPLEMENTATION

The Department of Mental Health continues to regard the length of time from hospitalization to medication of individuals who are sick and dangerous as a particularly problematic aspect of Act 114 as currently implemented. Typically patients are held in the Vermont State Hospital against their wishes for over 60 days for the process to unfold—and this is an improvement over previous years. Thus Act 114 still has unreasonable delays in care for persons who ultimately are found to lack capacity.

At the beginning of 2009, DMH does not have a specific legislative change to offer on Act 114 but does find the current situation not to be in line with humane care. The Department intends to continue to discuss these concerns with legislators and welcomes those who agree or disagree with this perspective to do the same. Whether the resolution of this concern is through a change in current legislation, creation of new legislation, or some other avenue of change, DMH will continue to argue that the current lengthy process is not to the benefit of patients with compromised ability to reach recovery. At the same time, DMH will continue to promote its position that medication is only one avenue for recovery and that every effort should be made to find a collaborative manner to work with involuntary patients.

See additional information below, under the section on Opportunities for Improvement, page 13.

NUMBER OF PETITIONS FOR INVOLUNTARY MEDICATION FILED BY THE STATE PURSUANT TO 18 V.S.A. §7624 AND THE OUTCOME IN EACH CASE IN CALENDAR YEAR 2008

In all, the Commissioner of the Department of Mental Health filed 24 petitions for non-emergency involuntary medication of patients at VSH from January 1 through December 31, 2008. Seven of those petitions were withdrawn prior to hearing because the patients began taking medication voluntarily. The court granted the state's request in 15 of the remaining cases and issued orders for involuntary medication. The court denied the state's request in one case, and one petition was pending as of the end of December 2008.

COPIES OF ANY TRIAL COURT OR SUPREME COURT DECISIONS, ORDERS, OR ADMINISTRATIVE RULES INTERPRETING §4 OF ACT 114

No significant trial court or Supreme Court decisions or orders were forthcoming in 2008, nor were any administrative rules interpreting §4 of Act 114.

INPUT FROM ORGANIZATIONS AS REQUIRED BY ACT 114

Act 114 requires DMH to solicit comments from organizations representing persons with mental illness and organizations representing families with members with mental illness, direct-care providers, persons who have been subject to proceedings under 18 V.S.A. §7624, treating physicians, attorneys for the patients, courts, and any other member of the public affected by or involved in these proceedings.

To meet this statutory mandate, DMH solicited input in writing from:

- Vermont Psychiatric Survivors (VPS), a statewide organization of adults with experience of severe mental illness
- the National Alliance on Mental Illness of Vermont (NAMI—VT), the state chapter of the national organization of families of adults with severe mental illness
- the Washington County Family Court, which hears applications for commitments and involuntary non-emergency medication
- the Mental Health Law Project, which offers legal counsel to Vermonters with low incomes, who are elderly or who have disabilities
- Vermont Protection and Advocacy (P & A), a statewide organization offering information and support, referrals to other agencies, and advocacy and legal representation for individuals with disabilities and/or mental-health issues, and

- the individuals who received psychiatric medication involuntarily at VSH (two who were involuntarily medicated in 2007 but submitted their questionnaires in 2008 are included in this report for 2008)

Among the organizations and the state entity from which DMH solicited input for this report, VPS, NAMI—VT, and Judge Amy Davenport of the Washington County Family Court responded. DMH central office staff met with VSH physicians, nurses, and psychiatric technicians on November 18 and 21, 2008, to solicit their input for this report. Four patients who received involuntary non-emergency psychiatric medication, two of them in 2007 and two in 2008, responded to the Commissioner's questionnaire after the Act 114 report that was filed on January 15, 2008. Those four replies are included in the 2008 report for filing on January 15, 2009.

The questionnaires for organizations all asked the same six questions:

1. Were you directly involved with any individuals involuntarily medicated under Act 114?

2. Are you aware of any problems encountered in the implementation of this process?

3. What worked well regarding the process?

4. What did not work well regarding the process?

5. In your opinion was the outcome beneficial?

6. Do you have any changes to recommend in the law or procedures? If so, what are they?

Input from Vermont Psychiatric Survivors (VPS)

Rather than respond to the individual questions, Linda Corey, Executive Director of VPS, submitted her comments as follows (quoted verbatim):

> Our concern remains the same as to the dangers of side effects and in some cases death of medications. We understand the dilemma that people face when trying to get stabilization of crisis. We feel that alternative approaches should be considered and medication not be the end all solution. Given the publicity of numerous lawsuits of pharmaceutical companies in the past year, I feel this does demonstrate a need to be aware and explore ideas. On the other hand we have had peers find the right medication and feel their life is better and are well aware of the side effects. This opens the door for the need to be educating peers on side effects. They then can catch warning signs and talk to the doctor about them. I think the ultimate issue is forced vs. freedom of choice. This issue will continue as long as there is forced treatment. I personally don't have the answer or solution. Having seen the results on both sides, severe health issues or death resulting from medication and others that have regained their life in the community and are contributing to the community not just maintained; I only hope all options are explored before any forced treatment. Trauma is another concern as well. There needs to be much more trauma informed care throughout our system. Medications can mask the problem but doesn't cure trauma. This is according to literature I have seen. I gave Trish [Patricia Singer, the new Director of Adult Mental Health at DMH] a dvd I got at the Alternatives conference called Broken Wings. It explains some of these points through personal stories. If we can start having dialogue using this type of literature I think it would be helpful.

Input from the National Association on Mental Illness of Vermont (NAMI—VT)

1. Were you directly involved with any individuals involuntarily medicated under Act 114?

We were not directly involved with any individuals involuntary mediated under Act 114, in terms of our direct service role through the information & referral warm line and our family and provider education programs, operated under our contract with DMH.

2. Are you aware of any problems encountered in the implementation of this process?

Anecdotally, we occasionally hear stories from family members whose loved ones living with mental illness have had issues with taking (or refusing) medications while confined at VSH, but these are few & far between. We have been party to several policy discussions at the State House, the Transformation Advisory Council and other

venues on this subject, but have no first-hand experience with problems in the current Act 114 process.

3. What worked well regarding the process?
4. What did not work well regarding the process?

Generally, what we hear is that VSH patients either are (or are not) compliant with medications & wait a long time to have their cases heard, when they refuse meds. Family members tell us that, when they visit VSH patients who are not on meds, their loved one doesn't seem to be getting better. We sometimes hear frustration about the apparent lack of progress from those who do not accept meds. But over time, these patients tend to get better.

5. In your opinion, was the outcome beneficial?

I believe the outcome is generally better for patients who accept meds, although the side effects can be quite problematic if not closely monitored. The larger problem often arises following the patients' discharge, in terms of ongoing compliance with medication outside the hospital setting. I believe the designated agencies have insufficient medical resources and staffing to properly monitor former patients' ongoing issues with controlling symptoms and keeping side effect impacts in check.

6. Do you have any changes to recommend in the law or procedures? If so, what are they?

NAMI—VT's leadership spent considerable time & effort debating & developing the attached policy statement on involuntary treatment and the future of the VSH Futures plan this year.

(Note: For NAMI—VT's policy statement, please see Appendix.)

Input from Washington County Family Court

In a letter of November 22, 2008, to Mental Health Commissioner Michael Hartman, Judge Amy Davenport noted that hearing court proceedings related to Act 114 from January 1 through October 27, 2008, required twenty-three hours of hearing time in court. She estimated that writing findings required an additional fifteen hours.

Judge Davenport began hearing these cases in 2007 and continues to hear them when she is available. When she is not available, a retired judge, usually Judge Stephen B. Martin, hears them.

Judge Davenport noted that, from her perspective, the Act 114 process "appears to be working well. It is occasionally difficult to hear applications on the merits within the seven day time frame because of holidays or because Legal Aid is unable to schedule an independent evaluation of the litigant. If we are unable to hold a hearing within the

seven day time frame, we make every effort to get the case scheduled as quickly as possible thereafter." In addition, she observed that involuntary medication hearings are usually held on Wednesdays in Waterbury. She explained that "the attorneys have a phone conference with the clerk, Ruth Sicely, the Friday beforehand to discuss settlement negotiations. This strategy has worked well and allowed us to use the court time effectively."

Input from Individuals Who Were Involuntarily Medicated at the Vermont State Hospital (VSH)

Questionnaires sought feedback in three ways from patients who had been involuntarily medicated at VSH through the end of 2008:

- By sitting down in person with the Commissioner of Mental Health (Deputy Commissioner before July 1, 2007),
- Through either written answers or interviews with a social worker or nurse while still at VSH, and
- Through written answers to the questionnaire after leaving VSH

Four patients answered the questionnaires in time for inclusion in DMH's legislative report for January 15, 2009.

The Commissioner's questions and the patients' answers are as follows:

1. Do you think you were fairly treated even though the process is involuntary?

   Yes: 1
   No: 3

The patient who answered yes to this question did not elaborate on her answer. One of the three patients who answered no added, "I do not think shots are ever the answer and I was not allowed to appear in court." A second patient felt that the process is unfair because it is "base[d] on low income." The third patient who answered no explained that he "wasn't allowed to ask questions" nor was he "allowed to bring witnesses" to court. About his experience at VSH, this patient said that "the doctor is a moron [and] I'm not mentaly [sic] ill."

2. Do you think that the advantages and disadvantages of taking medications were explained clearly enough to help you make a decision about whether or not to take them?

   Yes: 3
   No: 1

None of the respondents commented further on their answers to this question.

3. Why did you decide not to take psychiatric medications?

One patient answered "because I am schizophrenic." A second patient answered, "I never did." A third wrote "yes" without offering any explanation, while the fourth asserted that "I don't need psychiatric medications theirs [sic] nothing wrong with me."

4. Now that you are on medication, do you notice any differences between the times you are taking your medications and the times you are not?

   Yes: 2
   No: 2

One of the patients who answered yes to this question wrote, "I know what's going on," while the other one wrote, without explaining, "To change." Neither patient who answered no offered further information or explanation.

5. Was anyone particularly helpful? Anyone could include staff at VSH or a community mental health center, a family friend, a neighbor, an advocate, someone else who is in the Vermont State Hospital—really, anyone.

   Yes: 3
   No: 1

The respondent who answered no to this question went on to add, "My family doesn't want me on shots!"

   Who was helpful?

One of the three patients who answered yes to this question wrote "my mother and grandmother," another one wrote "the staff" without specifying anyone in particular, and the third mentioned "the regular staff that have known me over the years."

   In what ways was he/she helpful?

The respondent who indicated that her mother and grandmother were helpful said that they did so by "talking to me on the phone." The respondent who mentioned staff in general added the phrase "To Question being answer," with no clarification on the comment. The respondent who mentioned "regular staff" added that they "did not agree with the meds or length of time I was hear [sic] July-Dec[.] They would give me extra cigs and agree that I'm not ill."

6. Do you have any suggestions for changes in the law called Act 114? Please describe the changes you would like to see.

Three of the respondents had no suggestions for changes in the law. One answered this question by writing, "I just don't know. I've seen people who definiatly [sic] need meds."

Input from VSH Psychiatrists, Nurses, and Psychiatric Technicians

The Commissioner's questions and the responses from VSH staff were as follows:

1. How well overall do you think the protocol for involuntary psychiatric medication works?

VSH staff continue to express considerable dissatisfaction with the Act 114 protocol. Their concerns include:

- A general perception that the process as a whole is cumbersome and does not work well
- From the staff's point of view, the process is too long from admission of a patient to the point at which medication can begin
- The perception that Vermont is unique among the states in having a process that is so protracted
- The process denies treatment to individuals who need it, causing their condition to worsen and lengthening their stay in a restrictive inpatient setting
- It causes undue stress and mental anguish to both patients and staff over weeks and months when, ideally, treatment could be started much sooner
- 90-day medication orders are too short
- The policy making VSH the only hospital in the state where involuntary psychiatric medications in non-emergency situations can be given
- Heavy paperwork associated with documentation that the steps of the process have been followed

2. Which of the steps are particularly good? Why?

None of the staff had much good to say about the Act 114 process. A tentative suggestion that perhaps a support person present when medication is administered could be helpful succumbed to a discussion in which consensus formed on the possible dangers of such an approach (it could be more upsetting, even traumatic, for the patient; it could also pose risks for breach of confidentiality). In any case, no VSH staff could recall a single patient who had asked for a support person at the time of involuntary medication.

3. Which steps pose problems?

Many of the staff answers to this question were variations upon the shortcomings of the law that they noted in response to question no. 1. Additional staff concerns had to do with:

- The excessive length of medication hearings, once they get started
- The court's interference, as staff see it, with the ability of doctors to prescribe medications and dosages according to their best judgment about the clinical needs of their patients

- A reluctance to see a role for courts in determining medical treatment in the first place (there is no such role for courts in other fields of medicine, according to the staff)
- Admitting expert testimony on behalf of patients from psychiatrists who are considered to be outside "accepted practice" (and judges, for the most part, do not know what is accepted practice and what is not, said the staff)
- Sometimes lengthy waits from a hearing to the judge's decision
- The high turnover of judges in family court
- 30-day reviews of the continued necessity of medication once started
- Lack of certainty about when lawyers inform patients of medication orders

As they did last year, VSH staff again expressed dissatisfaction over the requirement for annual reports from the Commissioner to the General Assembly. They have spoken up year after year, they said, and they have not seen any changes or other response to their repeated concerns in regard to Act 114. They have the feeling that no one is paying attention to the issues they have raised. Some staff observed that consumers, family members, and other advocates have been permitted to offer testimony about Act 114 to lawmakers and wondered if they could do the same to try to tell their side of the story.

Another concern, not directly with Act 114 itself, revolved around advance directives and the ways in which those legal instruments were seen as inhibiting options for effective treatment for some individuals.

4. What did you do to try to get these patients to take psychiatric medications voluntarily before deciding to go the involuntary route through the courts?

Many staff talked about education and the importance of spending time with patients to explain how medications help control the symptoms of mental illness as well as time spent trying to understand why patients do not want to take something that can make them well. Information sheets and information groups were mentioned as other ways to help patients get the information they need. To help patients overcome fears of side effects, hospital staff often talk about dosages and strategies for dealing with unwanted side effects.

5. How long did you work with them before deciding to go through the courts?

The actual amount of time spent can vary quite a lot from individual to individual, depending on the length of time it takes to obtain a medication order. Staff try to work with patients from the first day they come into VSH until the order comes through. The process can be even longer for forensic patients, since a competency hearing must be added to the usual commitment and medication hearings for individuals admitted to VSH for emergency examinations.

6. How helpful or unhelpful was it to be able to give the medications when you did? In what way(s)?

VSH staff were unanimous in their agreement that medications help patients in an almost infinite variety of ways. Examples mentioned include:

- ☑ Reducing symptoms
- ☑ Enabling patients to regain control over their agitation and anger
- ☑ Improving the overall functioning of patients
- ☑ Regaining interest in other people and activities
- ☑ Making it possible for those with co-occurring physical conditions to get treatment for those as well
- ☑ Resuming their lives in the community

7. What do you think the outcome(s) would have been for the patients who were medicated if they had not received these medications?

Staff saw bleak outcomes for individuals who go unmedicated. Possibilities included:

- ☑ Longer stays, perhaps indefinitely, in VSH or other psychiatric institutions
- ☑ Death or jail for individuals who are dangerous
- ☑ Missing out on months and years of their lives with family and friends if patients continue to refuse medications
- ☑ More serious illness, both physical and mental
- ☑ Frustration, possibly leading to assaultive or self-injurious behavior
- ☑ Lowered chances for recovery or even getting back to baseline functioning

8. Do you have any recommendations for changes in Act 114?

Ideas for changing Act 114 were the same as those offered last year, or very similar. They included:

- ✪ Expediting the Act 114 process
- ✪ Extending the 90-day time frame for medication orders
- ✪ Permitting the administration of involuntary psychiatric medications in non-emergency situations in other hospitals in the state

CONCLUSIONS

What Is Working Well

With so little information from so few patients who were involuntarily medicated at VSH in 2008, it is impossible to say what is working well for them. At least one patient, though, did see a positive change in her condition after finally receiving medication, and the same has been true for many of the patients who have answered the Commissioner's questionnaire in the past. The VSH staff who participated in the interviews for this report were unanimous in seeing positive outcomes for clients after medication.

Opportunities for Improvement

Focus on Recovery

> "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential."[1]

The National Consensus Statement on Mental Health Recovery from the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA), which appears in last year's report, is worth repeating in this one as a reminder of the importance of keeping our focus on recovery as the "single most important goal" for the mental-health services delivery system.[2] The ten components and concepts fundamental to recovery are:

- Self-direction
- Individualized and person-centered supports and services
- Empowerment
- A holistic approach to recovery
- A non-linear process in working toward recovery
- Strengths-based interactions
- Peer support/mutual support
- Respect
- Responsibility
- Hope

Maximizing Individual Choice

The Department of Mental Health's opportunities for improvement, specific to the implementation of Act 114, lie within exploring ways to maximize individual choice whenever possible. The Vermont Futures Initiative, which is directed toward replacing some of the capacities of the inpatient care setting at the Vermont State Hospital as well as further development of new and more financially sustainable community services, is the state's most significant attempt to provide more consumer choices for adults with severe mental illness.

Shortening the Time from Hospitalization to Psychiatric Medication

DMH research on the Act 114 process in 2008 through the end of November found that the average time frames for the three major steps that must be completed for patients are:

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[1]http:mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/

[2]Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *Transforming Mental Health Care in America, Federal Action Agenda: First Steps*, DDHHS Pub. No. SMA-05-4060 (Rockville, Maryland: 2005), p. 4.

- 26 days average/25 days median from hospitalization to commitment hearing (as compared with 33-day average in 2007),
- 20 days average/13 days median from commitment hearing to application for involuntary medication (as compared with 27-day average in 2007), and
- 22 days average/19 days median from the beginning of the medication application process to a decision by the Family Court judge (as compared with 26-day average in 2007)

The range for the third step of the Act 114 process was as few as six and as many as 55 days over the same time period.

All of the three steps of the process are now shorter than in 2007. This reduction came about without having more applications or orders granted in 2008 than in the previous year. In fact, fewer orders (15) were granted in 2008 than in 2007, when 19 orders were granted.

DMH and VSH have taken administrative measures to reduce the amount of time required for the middle step, from commitment to application for medication. As noted above, this time frame was reduced from 27 days in 2007 to 20 days in 2008. To work toward further reductions, we are engaging in additional research and further discussions with the administration, legislators, and advocates to gain support to improve upon these timelines. In addition, DMH is talking to representatives from the National Association of State Mental Health Program Directors (NASMHPD) and has consulted the Bazelon Center for Mental Health Law in regard to making changes without decreasing the legal protections that individuals have.

APPENDIX

NAMI—Vermont Policy on Involuntary Treatment & Medication

As approved by the Board of Directors — 2.25.08

As family members and individuals personally affected by mental illness, we believe that most people with mental illness can & should be treated in the community, rather than in hospitals. Only a small number of these individuals will require hospitalization during an acute phase of their illness. Fewer still (less than 5% of those affected by serious mental illnesses in Vermont) should ever be referred for involuntary hospitalization and/or involuntary medication.

However, we also see that many individuals experiencing psychosis due to acute mental illness lack insight of the impact of their symptoms on themselves and others. This lack of insight leads some acutely ill individuals to refuse any form of treatment, including hospitalization and/or medications. Left untreated, these individuals are more likely to harm themselves, and experience deterioration in their cognitive, emotional and physical condition.

In Vermont, current law allows attorneys for the state, upon the recommendation of a treating physician at the hospital, to petition for an order to compel patients into involuntary treatment (IT) in a locked hospital ward. The state may also petition to authorize hospital staff to administer involuntary, non-emergency medications (INEM). These forms of treatment cannot proceed until a judge grants these orders, if the patient continues to deny their illness and refuse care.

As legislators contemplate possible changes to current law, NAMI—Vermont suggests the following points be taken into consideration:

1. We support Vermont's current values that favor community-based care over hospitalization, and voluntary psychiatric care over coercion of any kind. We believe that access to effective psychotropic medications is an important foundation in treatment for individuals with acute mental illness, along with access to counseling, treatment of any co-occurring physical illness or substance abuse, healthy nutrition and exercise, and peer supports.

2. Most individuals with serious mental illness accept treatment and medications, when they have access to care and have the capacity to make informed choices. **The state's coercive power to force involuntary treatment should only be pursued as a last resort, when all attempts to engage the individual in voluntary care have failed, and when an individual's behavior puts them at risk of harm to self or others.**

3. We believe that only psychiatrists have sufficient training and experience to make this determination. Hospitals should not rely upon a quick judgment by unlicensed crisis workers or the general medical staff to determine the patients' need for inpatient psychiatric care. The patient's past history, as well as current symptoms, should also be considered in assessing the need for hospitalization.

4. Current research suggests that the longer an individual's psychosis remains untreated, the more difficult the individual's path to recover. Some forms of mental illness can even be fatal: for example, 1 in 3 people with acute schizophrenia will attempt suicide, and 1 in 9 will kill themselves. However, we believe Vermont's current laws that govern the legal process for involuntary treatment actually delay acutely ill individuals' access to care.

   In a recent study, 20 psychiatric patients waited an average of 109 days for a final decision on the state's petition for involuntary medication. (Note: while awaiting the judge's decision, patients are often subject to forced emergency medication and physical restraints, when their behavior puts themselves, other patients or hospital staff at risk.)

5. One important source of delays in the current process comes from our community hospitals. Even though they are currently under contract with our state Dept. of Mental Health to provide inpatient psychiatric services, these hospitals now transfer psychiatric patients believed to need non-emergency involuntary medication to the VT State Hospital, in all cases. The state should enable and encourage community hospitals to provide this type of care in-house, to expedite patients' access to comprehensive psychiatric care close to home.

6. **NAMI—Vermont favors changes to current practice and statute that would lead to a more prompt medical and legal determination of the need for involuntary treatment, and more prompt access to active treatment when an individual lacks the capacity to make informed decisions about their care.** Within 30 days of admission to a Vermont hospital for an emergency evaluation, psychiatric patients believed to be in need of involuntary treatment should have access to and receive the following:

   - A prompt determination of their decision-making capacity by a treating psychiatrist
   - A separate evaluation of their need for involuntary psychiatric hospitalization and involuntary medication, by a second psychiatrist
   - Only if these evaluations find both a lack of capacity AND a need for treatment, a prompt filing by attorneys for the state of petition(s) for involuntary care
   - Appointment of competent legal representation for the patient

- Active treatment (including non-emergency medication) should begin immediately, while decisions on the patient's case are pending in court
- The judge's decisions on continuing involuntary hospitalization and/or medication should be conveyed promptly to the patient and the hospital staff

Our current process in Vermont clearly does not meet these minimum standards. Lengthy delays in providing active treatment to the patient, while the legal process slowly runs its course, serve no one's interest. Public policy and law should support psychiatric patients' right to be well & facilitate prompt access to the best care available. For Vermonters who are subject to this cumbersome process today, treatment long delayed becomes treatment denied.

7. A more timely decision on the need for involuntary treatment and/or involuntary medication, with care commencing promptly if medically indicated & endorsed by a judge, would:

   - Reduce hospital lengths of stay, returning patients to the community sooner
   - Reduce the rate of injuries to patients & staff at the VT State Hospital
   - Reduce the numbers of seriously mentally individuals who are arrested and jailed for non-violent offenses because they sought & were refused hospitalization
   - Be more consistent with the goals of mental health parity (equal treatment of symptoms of mental and physical illness). As a society, we generally do not tolerate long delays in applying a life-saving procedure. We just expect critical care to be given, and lives to be saved, to the best of our medical providers' ability, even when the patient does not cooperate. The standard of care for an individual at risk of harm to self and others due to psychosis should not be any different.

8. NAMI—Vermont favors substituting a competency-based standard for determining an individual's ability to make informed decisions about psychiatric treatment, for the current prolonged and court-centered process. While the decision to treat someone involuntarily and a decision to medicate should remain two separate decisions under law, we support combining the evidentiary process and hearing on both petitions, to facilitate a prompt decision on the patient's case.

9. We should not let this debate divert us from what's really important in the State Hospital Futures plan, and our efforts to strengthen Vermont's entire system of mental health care: Vermonters with serious mental illness need access to a full spectrum of care, when and where it's needed. Reforms in practice and law on this issue will not change the need for continued public investments to strengthen our community-based system of care, both in

hospitals and through our dedicated public and private mental health care providers.

Our priority in Vermont should be making high quality, affordable mental health care accessible to everyone who needs it. Long-term, we believe this will lead to fewer individuals with serious mental illness having to be hospitalized whether voluntarily or involuntarily. That outcome would be good for patients and their family members, good for our communities, and is far more cost-effective in the long term for the taxpayers.

NAMI welcomes further dialogue with other stakeholders on these issues, and will be open to consider a variety of evidence-based solutions that meet these standards. We hope that Vermont legislators and policy makers will work to address and fix the flaws in our current process, as we work together to design a more recovery-oriented system of care for individuals with acute symptoms of mental illness.

For more information about NAMI—Vermont & our advocacy efforts, including our complete Advocacy Agenda, see our website at www.namivt.org, *or call* 1-800-639-6480. *Comments & suggestions about this policy statement? Contact: Larry Lewack, Executive Director, at* namivt1@verizon.net.